



Health Technical Services Project



Discussion Papers on HIV/AIDS Care and Support

Human Rights and HIV/AIDS

Prepared by
Zita Lazzarini

Discussion Paper Number 2

June 1998

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

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About HTS

The Health Technical Services Project provides short- and medium-term technical assistance to USAID — specifically, to regional bureaus, regional and country missions, and the Office of Health and Nutrition in the Center for Population, Health and Nutrition of the Bureau for Global Programs, Field Support, and Research (G/PHN/HN). This technical assistance supports USAID programs in maternal and child health, nutrition, health policy reform, HIV/AIDS, and environmental health. HTS activities are concentrated in three broad technical areas: project design, policy and strategy, and evaluation and monitoring.

HTS's work is grounded in the four complementary values that guide USAID's efforts to reengineer its operations:

- # a customer focus
- # participation and teamwork
- # empowerment and accountability
- # management for results.

Foreword

The U.S. Agency for International Development seeks to develop and promote effective strategies for providing basic care and support to those affected by HIV/AIDS. This series of Discussion Papers on HIV/AIDS Care and Support represents a first step in this effort.

HIV/AIDS care and support mitigate the effects of the pandemic on individuals, families, communities, and nations. Such interventions are an important component of the overall response to HIV/AIDS because they increase the impact of prevention strategies and mitigate the negative consequences of the epidemic on the prospects for sustainable development.

This series of Discussion Papers covers several key issues related to care and support:

- # Human rights and HIV/AIDS
- # Palliative care for HIV/AIDS in less developed countries
- # Preventing opportunistic infections in people infected with HIV
- # Psychosocial support for people living with HIV/AIDS
- # Community-based economic support for households affected by HIV/AIDS
- # Responding to the needs of children orphaned by HIV/AIDS
- # Systems for delivering HIV/AIDS care and support.

Each paper provides a preliminary review of some of the current thinking and research on these broad and complex topics. It is important to note that the papers are not meant to be comprehensive — time and resource constraints prevented the authors from reviewing all the relevant literature and from contacting all the people who have valuable experience in these and related fields. Nor have they been subject to technical or peer review. Their purpose is to stimulate a broad conversation on HIV/AIDS care that can help USAID define its future program activities in this area. We welcome your participation in this process.

Two additional papers on the topic of voluntary counseling and testing were prepared with USAID support:

Discussion Papers on HIV/AIDS Care and Support

The Cost Effectiveness of HIV Counseling and Testing

Voluntary HIV Counseling and Testing Efficacy Study: Final Report

These two papers are available from the IMPACT Project, Family Health International, 2101 Wilson Boulevard, Suite 700, Arlington, VA 22201; www.fhi.org.

Please direct your requests for copies of papers in the Discussion Series on HIV/AIDS Care and Support and your comments and suggestions on the issues they address to the Health Technical Services (HTS) Project, 1601 North Kent Street, Suite 1104, Arlington, VA 22209–2105; telephone (703) 516-9166; fax (703) 516-9188. Note that the papers can also be downloaded from the Internet at the HTS Project's web site (www.htsproject.com).

—Linda Sanei, Technical and Program Advisor,
Health Technical Services Project

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Human Rights and HIV/AIDS

The human rights framework recognizes the centrality of health to the enjoyment of fundamental human rights, but the right to health is poorly defined in international instruments. HIV/AIDS prevention and care programs engage the full range of human rights — those freedoms and entitlements invested in each person at birth which are universal and inalienable. International human rights instruments explicitly recognize that only non-derogable rights are absolute; other rights may be limited under certain circumstances, but the power to restrict such rights is narrowly proscribed. To prevent the further spread of HIV while simultaneously protecting the human rights of those who infected with HIV and those who are not, HIV/AIDS policymakers must review the legality of HIV/AIDS policies; evaluate their public health goals; assess whether the policies can achieve those goals; and weigh whether the benefits outweigh the financial and human rights burdens.

In the last fifty years, human rights have emerged as an internationally recognized body of principles fundamental to the promotion of peace.¹ These principles have been codified in the founding documents of the United Nations (the UN Charter), the International Bill of Human Rights,² and many other treaties and international

¹United Nations Charter (UN Charter), signed June 26, 1945, entered into force October 24, 1945, preamble and Article 1; Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, preamble.

²UDHR; International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, entered into force January 3, 1976;

declarations. Human rights principles, declarations, and treaties have had a normative effect since their adoption. They also form the basis for a system of reporting, monitoring, and enforcement of human rights that has yet to be fully realized.

Respect for individual dignity and the worth of every human being is a central element of international human rights.³ Respect for human dignity requires, at a minimum, that states and individuals recognize that each person has freedoms to exercise and certain needs that must be met if he or she is to survive and achieve his or her full potential.

Good health is fundamental to the enjoyment of other human rights, but the right to health is poorly defined in international human rights instruments. This discussion paper explores the integral connections among some fundamental human rights and program interventions to promote health, prevent disease, and provide health care to those who are ill, including those affected by HIV/AIDS. It then examines how the protection of human rights can be incorporated into the prevention and care continuum—the range of programs interventions launched in response to HIV/AIDS which increase the impact of prevention strategies and mitigate the negative consequences of the epidemic on the prospects for sustainable development.

HUMAN RIGHTS AND HEALTH

The human rights framework recognizes the centrality of health to the enjoyment of fundamental human rights. People highly value good health, which can include protecting infants and children from deadly childhood diseases; avoiding illness and disability due to accident, injury, epidemic, or chronic diseases; and maximizing each person's physical ability to work, rear children, and contribute to society.

International human rights emphasize health, both directly and indirectly:

- # The UN Charter commits the United Nations to promote solutions for international health problems (Article 55).

International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, entered into force March 23, 1976; Optional Protocol to the International Covenant on Civil and Political Rights, adopted December 16, 1966, entered into force March 23, 1976.

³UN Charter, preamble; UDHR, preamble and Article 1; ICCPR, preamble; ICESCR preamble.

- # The Universal Declaration of Human Rights (UDHR) conceives of health in the context of a full life and includes a right to “a standard of living adequate for the health and well-being of individuals and their families” (Article 25).
- # The International Covenant of Economic, Social and Cultural Rights (ICESCR) declares “the right of everyone to the highest attainable standard of physical and mental health” (Article 12).
- # The Convention on the Rights of the Child asserts the right of children to enjoy the “highest attainable standard of health” (Article 24(1)).
- # Other treaties pledge states to fight discrimination in access to health care, based on gender or race⁴
- # International organizations such as the World Health Organization (WHO) have integrated human rights into strategies to address health issues. For example, the WHO Constitution states, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, or political belief, economic or social conditions.”
- # Regional human rights charters and some national constitutions recognize a right to health.⁵

The right to health remains poorly defined in international instruments, however. If the right to health is to be more than an unenforceable aspiration, an international consensus must be reached on a definition that provides not only an entitlement, but corresponding obligations as well (Leary 1994).

The right to health can be defined as

the duty of the state, within the limits of its available resources, to ensure the conditions necessary for the health of individuals and populations. (Gostin and Lazzarini, 1997)

⁴Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12; Convention on the Elimination of All Forms of Racial Discrimination, Article 5(e)(iv).

⁵African Charter on Human and Peoples’ Rights, Article 16; American Declaration of the Rights and Duties of Man, Article 11; European Social Charter, Article 11; Fuenzalida-Puelma and Connor (1989).

Although not perfect, this definition *does* establish some obligations for states and recognize the constraints of states' varying capabilities by requiring only that states act "within the limits of their resources." This definition *does not* make states the guarantors of individuals' health, since health is the product of many factors outside states' control, including genetics, behavior, population, and climate. It *does* require states to look beyond the provision of medical care to ensure the conditions necessary for health, including decent sanitation, hygiene, clean air and water, nutrition, clothing, housing, medical care, disease surveillance and control, vaccinations, and health education. It *does not*, however, establish a minimal standard for such "healthy conditions" or for health in general.

The Role of Human Rights in Health-Related Programs

National and international health programs have quietly implemented measures to both protect and promote human rights in recent years, a recognition of the importance of human rights to a variety of health issues. Some important lessons can be learned from these health efforts and from other international programs that relate to health.

- # Primary health care: The efforts by WHO, nongovernmental organizations (NGOs), and national governments to promote primary health care emphasize the importance of universal access to basic health care, free from discrimination on the basis of race, gender, social or economic status, or political identification.⁶ Ideally, primary health care services create a foundation upon which individuals and families can build to achieve not only better health, but more education, better jobs, and greater social and economic freedom.
- # Women's health: Efforts to promote women's health by ensuring greater access to family planning, pre- and post-natal care, adequate nutrition, and education recognize that, in many countries, women are deprived of the ability to be healthy by their low social status, including traditional or legalized discrimination in education, employment, and family law (Mann and Gruskin 1995; Cook 1995; Zierler and Krieger 1997). Married women who cannot consent to medical care without their husband's permission are often unable to obtain care they need, including emergency obstetrical care. When women are denied equal access to education, they are dependent on their husbands or fathers for support and vulnerable to being exploited, for example, as low-paid workers or sex workers,

⁶Declaration of Alma Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 1978.

- when they need to support themselves or their children. Promoting equal status for women is a key to promoting their health (Jackson 1998; Freedman 1995; Fischbach and Herbert 1997).
- # Family planning: Family planning programs are integral to the full realization of women's and men's reproductive rights. These programs ideally promote and protect the rights of adults to marry and found a family, determine the number and timing of their children, receive reproductive health care, and be free from coerced sex or child marriages (Tomasevski 1994; Cook 1992; Cook 1993). The best international and national family planning programs emphasize providing information about various methods and prompting men and women to choose the method that best suits their needs. Such programs founder when they are not based on voluntary choices by individuals and families. Indeed, coercive efforts to limit family size or increase the numbers of sterilizations have met with resistance in some areas and have increased distrust of government health initiatives in others (Kabra and Narayanan 1990; Moss 1992; Hartmann and Standing 1985).
 - # Child survival programs: Many national and international agencies are working to reduce infant and child mortality through immunization programs, growth monitoring, birth spacing, and nutritional support, among other means. Such programs directly promote children's rights by maximizing their potential for life and health, and they reflect some fundamental principles of human rights, including nondiscrimination and the special status of children as deserving of support and protection within their families and society.⁷ In addition, research shows that the children of mothers with more education have lower infant and child mortality rates, independent of other variables. Thus, educating girls is an important aspect of both child survival programs and women's health programs (UNICEF 1998).
 - # Rights of the mentally ill and disabled: In many countries, mentally ill or disabled people suffer discrimination, deprivation, and neglect. International human rights provisions recognize rights of the disabled and mentally ill.⁸ Basic standards for treatment of the mentally ill emerged from suits filed in the European Court of Human Rights and in courts within the United States, including a change in the

⁷UDHR, Articles 2, 16, 25; ICESCR, Articles 2, 10; Convention on the Rights of the Child, preamble, Articles 2, 6, 24, 26, 27.

⁸Declaration on the Rights of Disabled Persons (December 9, 1975); Declaration on the Rights of Mentally Retarded Persons (December 20, 1971); Convention on the Rights of the Child, Article 23.

status of such people in some countries and guarantees of fairness for criteria and procedures governing commitment and confinement in state-supported mental institutions.⁹ Similarly, litigation and legislation concerning the disabled have changed the way some societies provide care for such people and have expanded their opportunities to work and live independently.¹⁰

- # Microcredit: Microcredit services are intended to provide the poorest individuals and families with access to credit for self-employment and are based on the principles of nondiscrimination and equal access. Specifically, if the poorest families in a society are to gain access to the economic benefits available to others in society, they must have equal access to credit. Microcredit programs have proven effective in increasing household income, improving food security, improving living conditions, and elevating the status of women. All of these contribute to better health (Microcredit Summit 1997; McNelly and Dunford 1996).

THE RELATIONSHIP OF HUMAN RIGHTS AND HIV/AIDS

The relationship between health and human rights generally, and between human rights and HIV/AIDS in particular, is complex. Its most important characteristic is that it is not zero-sum, where protection of health is gained only at the expense of human rights, or where promotion of human rights leads to increased cases of HIV or other health risks. Maximizing individuals' enjoyment of health and human rights requires concerted action in both areas, as illustrated by at least three distinct relationships between health and human rights (Mann, Gostin, et al. 1994):

⁹*Addington v. Texas*, 441 U.S. 418 (1979); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *A. v. United Kingdom*, application no. 6840/74, Report of the European Commission of Human Rights, adopted July 16, 1980; *B. v. United Kingdom*, application no. 6870/75, Report of the European Commission of Human Rights, adopted October 7, 1981; *Van der Leer v. The Netherlands*, The Times, March 2, 1990, European Court of Human Rights, 1990; *Winterwerp v. The Netherlands*, 2 E.H.R.R. 387, European Court of Human Rights, 1979; *X v. United Kingdom*, 4 E.H.R.R. 188, European Court of Human Rights, 1981.

¹⁰*Nassau County School Board v. Arline*, 480 U.S. 273 (1987); Americans with Disabilities Act (1990), United States Public Health Law 101-336. See also UNHCHR (1996a), which cites national anti-discrimination provisions.

- # Relationship 1: Public health policies may burden human rights. HIV/AIDS policies that require testing, examination, or treatment violate the right to security of person unless they are based on fully informed consent. While human rights doctrine recognizes protecting public health as legitimate grounds for limiting certain rights, such limitations must be narrowly defined through formal procedures and must be subject to specific rules.¹¹ Even voluntary programs may burden human rights, for example, if they provide free or subsidized care, education, or other benefits but discriminate explicitly or in application against certain groups of people such as minorities, homosexuals, injection drug users, or sex workers.
- # Relationship 2: Human rights abuses measurably harm health. Gross abuses of human rights clearly harm health, such as those that occur in times of war or internal conflict (e.g., torture, extra-judicial executions, rape, imprisonment, and mass relocations). Some of these also may result in increased HIV infection among the victims (Breyer 1998). Peace-time human rights violations may seem more subtle, but they may contribute more profoundly to increased HIV infection rates and early deaths. For example, government or community policies that limit the free exchange of information about HIV/AIDS and how to prevent it deny individuals the knowledge they need to avoid infection or to obtain adequate treatment. Government policies that sanction discrimination against specific groups (i.e., according to race or sexual orientation) may deny individuals infected with HIV access to health care, which may increase their suffering, exacerbate their illness, and cause their early deaths.
- # Relationship 3: Promoting human rights is necessary to improve health. When women are dependent on men for support, are expected to defer to men, or are barred from initiating discussions about sexual practices, they are unable to insist on safer sex, which increases their risks of HIV infection. When women's economic security and social status are linked to bearing children, they have few incentives to practice safer sex, even with partners who may be infected with HIV. In such settings, promoting the rights of women and girls to equal education, rights in marriage, and access to jobs and credit can improve their health, in particular, by restoring their ability and incentives to protect themselves (Jackson 1998). Similar efforts to promote the human rights of other groups accorded subordinate social status may be necessary to reduce their rates of HIV infection and ensure their access to care (Zierler and Krieger 1997).

¹¹ICCPR, Article 4; ICESCR, Article 4; Siracusa Principles (UN 1984).

THE SYNERGY AMONG HUMAN RIGHTS AND HIV/AIDS PREVENTION AND CARE ACTIVITIES

Arguments that HIV/AIDS prevention activities are in direct competition with HIV/AIDS care activities for scarce resources, program space, and experienced staff are similar to arguments that maximizing public health and promoting human rights are mutually exclusive goals — both set up a false dichotomy. In fact, the same synergy that results when health officials seek to promote both human rights and public health, in which promoting one improves the other, applies to activities to prevent the spread of HIV/AIDS and activities to provide care to those affected by the pandemic.

In 1989, WHO defined care for people with HIV and AIDS as

a comprehensive, integrated process which recognizes the range of needs for wellbeing; it includes services and activities providing counseling and psychosocial support, nursing and medical care, legal, financial and practical services. (IFRC 1995)

Both HIV/AIDS prevention and HIV/AIDS care programs can benefit from measures that promote trust, protect privacy, prevent discrimination, and provide adequate resources for treatment and social services to those who are infected with HIV and those who are not. Such measures can bring people forward for testing, promote healthy behaviors, and increase use of appropriate treatments. Creating conditions in which people are most likely to avoid infection, while fully enjoying their human rights, also can create conditions favorable to optimizing HIV care within a society.

Protected Human Rights

HIV/AIDS prevention and care programs engage the full range of human rights — those freedoms and entitlements invested in each person at birth which are universal and inalienable.¹² International law protects two major categories of human rights: civil and political rights, on one hand, and economic, social, and cultural rights, on the other (see Figure 1).

¹²As defined in the UDHR, ICCPR, ICESCR; Convention on the Rights of the Child, CEDAW, and others.

“Negative” Rights

In general, civil and political rights protect individuals from a loss of freedoms or from restraints on individual liberties, unless those restraints fit into narrowly defined exceptions permitted to achieve compelling state interests. These are sometimes called “negative” rights, because they usually require the state to refrain from doing something.

HIV/AIDS programs can impermissibly infringe on many of these rights, including:

- # the right to autonomy, founded on security of person (i.e., through compulsory testing, examination, or treatment programs)
- # the right to privacy (i.e., through disclosure of a people’s HIV status that is neither morally justified nor required by law)
- # the right to liberty (i.e., by confining people with HIV infection based on their status alone rather than on dangerous behavior)
- # the right to free exchange of information (i.e., by censoring health or scientific information necessary to help people protect themselves).

Figure 1. Rights Included in the International Bill of Human Rights	
Civil and Political Rights	Economic, Social, and Cultural Rights
<p>P Self-determination</p> <p>P <i>Freedom from discrimination</i></p> <p>P Equal enjoyment of rights by men and women</p> <p>P <i>Life</i></p> <p>P <i>Freedom from torture and cruel, inhuman, or degrading treatment or punishment</i></p> <p>P <i>Freedom from slavery or involuntary servitude</i></p> <p>P Liberty and security of person</p> <p>P Humane and dignified conditions of confinement (for those deprived of liberty)</p> <p>P <i>Freedom from imprisonment for failure to fulfill a contractual obligation</i></p> <p>P Freedom of movement</p> <p>P Equal treatment before the law</p> <p>P <i>Freedom from retroactive criminal prosecution</i></p> <p>P <i>Recognition as a person before the law</i></p> <p>P Freedom from arbitrary or unlawful interference with privacy</p> <p>P <i>Freedom of thought, conscience, and religion</i></p> <p>P Freedom of opinion, expression, and information</p> <p>P Peaceful assembly</p> <p>P Freedom of association</p> <p>P Protection of the family</p> <p>P Freedom to marry and found a family</p> <p>P Protection as a minor, to a name and a nationality (for children)</p> <p>P Freedom to participate in public life, vote, and stand for election in free and fair elections</p> <p>P Equal protection of the law</p> <p>P Freedom to enjoy or use one's own culture, religion and language (for ethnic, religious, or linguistic minorities)</p>	<p>P Self-determination</p> <p>P <i>Freedom from discrimination</i></p> <p>P Equal enjoyment of rights by men and women</p> <p>P Work</p> <p>P Just and favorable working conditions</p> <p>P Freedom to form trade unions</p> <p>P Social security</p> <p>P Protection and assistance for the family, mothers, children, and young persons</p> <p>P An adequate standard of living</p> <p>P The highest attainable standard of physical and mental health</p> <p>P Education</p> <p>P Share in cultural life and enjoy the benefits of scientific progress</p>
<p>Notes: Summary of rights contained in the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The rights indicated in <i>bold italics</i> are considered absolute or "non-derogable" (ICCPR, Article 4).</p>	

“Positive” Rights

Economic, social, and cultural rights encompass fundamental entitlements, without which full and equal participation in society is difficult. These rights, often called “positive” rights, recognize the obligation of governments to work, within the constraints of available resources, to provide basic supports and opportunities to their people. The right to health, as defined above, incorporates an important body of state obligations, intimately involved in HIV/AIDS policies and programs. In addition, many other economic, social, and cultural rights are crucial in preventing HIV/AIDS and promoting health, including:

- # the right to work, because widespread unemployment leaves women and men unable to support their families and vulnerable to involvement in the sex or drug trades
- # the right to social security, for those persons no longer able to work due to illness or disability and for their families
- # the right to education, to fully realize human dignity and personality, to improve the health status of families, to prevent HIV infection, and to provide optimum care for individuals with HIV/AIDS
- # the right to development, for the poorest nations to accumulate adequate resources to fulfill their obligations to their people, and for the poorest individuals and families to lift themselves out of poverty, improve their overall health, and reduce their vulnerability to HIV/AIDS.

Other rights, perhaps equally important to HIV/AIDS prevention and treatment, include such positive rights as the right to share in the benefits of scientific progress, the right to an adequate standard of living, and the right to be free from hunger.

Absolute or “Non-Derogable” Rights

Some rights are so fundamental to individual dignity and well-being that they are treated as absolute or “non-derogable.” These rights can never be legally limited, restricted, or infringed upon by the state, or through acquiescence of the state, regardless of national emergency or perceived public health need (ICCPR, Article 4). Non-derogable rights include:

- # freedom from discrimination

- # the right to life
- # freedom from torture, cruel, inhuman, or degrading treatment or punishment (including medical or scientific experimentation without consent)
- # freedom from slavery or involuntary servitude
- # freedom from imprisonment for failure to fulfill contractual obligations
- # freedom from retroactivity for criminal offenses
- # the right to recognition as a person before the law
- # freedom of thought, conscience, and religion.

International Human Rights Protections

International human rights instruments explicitly recognize that only non-derogable rights are absolute; other rights may be limited under certain circumstances. The UN Declaration of Human Rights states

In the exercise of his [sic] rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society. (UDHR, Article 29.2)

Both the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) contain explicit provisions for restricting rights and limitations on those restrictions. However, the implementation requirements of the two covenants differ.

- # Signatory states to the ICCPR agree to take the steps necessary to adopt legislation or other measures that will give effect to the civil and political rights recognized in the ICCPR. The ICCPR aims for immediate or near-immediate realization of civil and political rights, including adoption of effective remedies for violations; determination of remedies by competent judicial, administrative, or legislative authorities; and enforcement of remedies by competent authorities. (ICCPR, Article 2)

- # The ICESCR requires that each state “undertakes to take steps individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view *to achieving progressively the full realization of the rights recognized in the...[ICESCR]...by all appropriate means, including particularly the adoption of legislative measures.*” (ICESCR, Article 2, emphasis added)

The inclusion in the original instruments of different timetables reflects the fact that states need more time and more resources to ensure economic, social, and cultural rights than to ensure civil and political rights. Generally, a state does not have to invest substantial time or resources to respect people’s rights to freedom from torture. On the other hand, a state does have to devote significant time and resources to invest in the infrastructure required to realize the right to education. Of course, some civil and political rights, traditionally classified as negative, require time and resources to realize. For example, holding free and fair elections requires, at a minimum, informing the electorate about the elections, providing access to the media for contestants, establishing and monitoring numerous polling sites, rigorously controlling the ballot-counting process, and preventing the corruption of election officials.

However, the important distinction for HIV/AIDS–related programs is that *while all states who have signed the ICCPR can be held to a minimum standard of compliance, realization of the rights in the ICESCR depends on the resources available to the country.* Nonetheless, even the most resource-poor states can and should be held accountable for making progress toward realizing economic, social, and cultural rights.

Since ratification of the International Bill of Human Rights, other declarations and conventions have defined and articulated rights particularly relevant to HIV/AIDS prevention and care activities. Some of these rights are protected elsewhere, but focusing on them as coherent bodies of inter-related rights can help policymakers address complex issues of social vulnerability.

- # Women’s reproductive rights are fundamental human rights recognized in international human rights conventions or conference declarations. These include the rights to life, health, and liberty; to found a family; to have access to family planning information and materials; to reproductive health care; to freedom from domestic violence and coerced sex; to equal rights in marriage; and to support and equitable distribution of property upon dissolution of a marriage. Reproductive rights remain controversial in some parts of the world.

- # Children's rights encompass such fundamental human rights as the right to protection of the family; to protection as a minor, to a name and a nationality; to social security; to protection and assistance for family, mothers, children, and young persons; to the highest attainable standard of physical and mental health; and to education.
- # The rights to equality, to equal treatment, and to nondiscrimination surface in any discussion of HIV/AIDS and human rights. The fundamental principle of nondiscrimination enjoins governments, institutions, and individuals from discriminating against people infected with HIV based on fears, prejudices, or invidious stereotypes. Nondiscrimination also requires states to take positive steps to eliminate or reduce discrimination against women, minorities, and socially disfavored groups and to extend to all members of society such benefits as primary health care and free education for children.

HIV/AIDS PROGRAM ELEMENTS AFFECTED BY HUMAN RIGHTS

Many specific HIV/AIDS program elements and policies raise human rights concerns, and some (but certainly not all) of these are reviewed below. In each case, the discussion identifies potential human rights concerns or indicates how policies to promote human rights would improve such program elements. Not all programs that burden human rights are wrong or unjustified, as discussed in the following section, which presents a framework for evaluating such issues.

National, Regional, and Local HIV/AIDS Strategy Development

Since the identification of the HIV/AIDS epidemic, health officials have recognized the importance of formal planning and strategy development for designing and delivering effective HIV/AIDS prevention and care programs. The WHO advised states facing an epidemic to form national HIV/AIDS planning or advisory bodies. Such coordinated planning can help policymakers respect or promote human rights by identifying priorities, preventing duplication of effort or conflict among policies, ensuring basic standards, and avoiding policies based on fear, ignorance, or prejudice.

To accomplish these goals, national, regional, or local strategy and policy development should incorporate the basic human rights principles described above and others that are important in the local context (e.g., protection of women's equal rights in and after marriage). Indeed, the current guidelines of the Joint

United Nations Programme on HIV/AIDS (UNAIDS) recommend national coordination as the first step for developing programs that respect and promote human rights (UNHCHR 1996a).

Epidemiologic Surveillance

Epidemiologic surveillance of HIV incidence and prevalence provides vital information to public health officials on the natural history of an HIV/AIDS epidemic, the allocation of resources available to respond, how to target prevention activities, and determining where the needs for care exist or are greatest. There are a variety of surveillance systems, none of which provides perfect data and each of which raises particular human rights concerns:

- # Voluntary or mandatory reporting of HIV infection and/or AIDS cases diagnosed by clinicians or laboratories: Reporting that uses names or other unique identifiers raises concerns about confidentiality, possible discrimination, and use of the information by government or private parties to penalize those affected by HIV/AIDS. Anonymous reporting or using a unique identifier that cannot be easily reconnected with patients' identities sacrifices some accuracy and makes it impossible to refer patients for treatment, although it allays concerns over confidentiality.
- # Prevalence studies among at-risk groups: Prevalence studies among those believed to be at high risk for HIV infection, including patients of clinics that treat sexually transmitted infections (STIs) or drug treatment programs, can provide useful data on the impact of the epidemic in a particular population or sub-population and on the potential for the future spread of HIV. However, such data may not be useful for making generalizations about the general population or even about similar groups in other geographic areas. Officials using such data may also unwittingly foster discrimination against already marginalized groups if members of the group are labeled as "disease carriers."
- # Sentinel and blinded surveillance: Blinded surveillance, where blood samples drawn for other purposes are tested for HIV, can provide unbiased surveillance data, but such systems are not based on consent, and those who test positive do not receive the results, are not referred for treatment, and are not educated about reducing future HIV transmission. Where a compelling public health purpose undergirds the collection of surveillance data, this loss of autonomy and lack of access to information may be justified, as long as the individuals involved have other opportunities for testing (WHO 1989e).

In establishing any surveillance system, public health officials should be aware of the intended and unintended effects of their programs, ensure adequate protections for confidentiality of any identifiable data, and strive to use data collected from particular populations to the eventual benefit of those populations.

Testing and Counseling

Testing and counseling programs are vital to HIV/AIDS prevention and care programs. Yet, without careful planning, such programs can heavily burden human rights and even defeat their basic public health purposes. Testing individuals without their voluntary, informed consent violates their right to security of person. If health officials disclose the results without permission, they also intrude deeply on the individuals' right to privacy and may provoke discrimination and even physical harm to them (North and Rothenberg 1993).

If public health officials test people for HIV infection but have no resources to offer treatment, education, or counseling, the testing is unlikely to yield substantial public health benefits. Moreover, fear of coercive policies may drive individuals at risk of HIV infection to avoid testing by choosing not to seek health care. Such fear corrodes trust in the public health system with potential long-term consequences for the public's health.

Private entities may also initiate testing programs that burden human rights with little public health justification. For example, testing for HIV infection by private employers often leads to breaches of privacy and confidentiality, discrimination, loss of livelihood, and even social ostracism. Employer testing for HIV should be limited to situations in which an HIV-infected employee would pose a direct and substantial threat to others that could not be easily eliminated or to situations where knowing employees' HIV status is vital.

In some limited situations, testing without consent may yield public health benefits and not unduly burden human rights. For example, if hospitals or clinics test donated blood or tissue and discard infected products, they can prevent new infections without impermissibly infringing on the rights of donors. Donors must be informed in advance that testing will be conducted, and test results must remain confidential.

In general, human rights concerns over HIV testing are reduced when the program incorporates the following elements (IFRC 1995):

- # informed consent, including pre-test counseling
- # confidentiality, both methodological and through provisions for legal protection and redress
- # safeguards against societal discrimination or violations of rights on the basis of HIV status
- # services and social support for those who test positive for HIV.

Education and Prevention Programs

Since the beginning of the pandemic, education has been critical to limiting the further spread of HIV/AIDS. Yet, many people who are at high risk of infection or are already infected have yet to receive adequate education about HIV/AIDS, how to prevent it, and how to care for people who are infected. Governments fail at HIV/AIDS education when they:

- # block the free exchange of information (i.e., censor health information)
- # fail to provide basic education to the population
- # neglect to share the benefits of science and technology by not disseminating important findings.

Perinatal Health Care and Prevention of HIV Transmission

Research has indicated that anti-retroviral treatment during pregnancy and the perinatal period can reduce perinatal HIV transmission by up to two-thirds. This created intense interest among clinicians, public health officials, and lawmakers in industrialized countries (Connor, Sperling, Gelber, et al. 1994). Clinicians have also improved their ability to treat children infected with HIV, prevent opportunistic infections, and prolong life.

Bringing these benefits to the pregnant women and newborns who need them has proved more challenging. In the United States and other industrialized countries, the prospect of sharply reducing perinatal HIV transmission has sparked debates over the proper role of consent in testing programs for mothers and newborns, the ethical justification for blinded newborn screening, and the right of women with HIV infection to bear children (Bayer 1994). As policymakers reconsider programs for perinatal HIV prevention and care, human rights concerns have focused on autonomy, privacy, nondiscrimination, and the right to found a family.

By 2000, more than 90 percent of women with HIV infection will live in developing countries, where access to anti-retrovirals is limited under any circumstances (Mann and Tarantola 1996; UNAIDS 1997). These countries largely lack the infrastructure and resources to identify pregnant women in need, treat women and newborns, and monitor them for complications from the drugs or for HIV transmission. For women in developing countries, perinatal health care and HIV prevention raise additional issues of justice (an ethical concept), which is embodied in human rights doctrine as the right to nondiscrimination and the right to share in the benefits of science and technology.

Ongoing studies into less costly means to reduce perinatal HIV transmission may lead to affordable interventions that could vastly reduce the rate of perinatal HIV transmission in developing countries. If researchers identify such regimens, the medical, technical, and human rights challenge will be to create and sustain an infrastructure capable of delivering even low-cost interventions to women in the poorest countries (Angell 1997; Lurie and Wolfe 1997; Varmus and Satcher 1997; Phanuphak 1998).

Work and Education Policies

Most people infected with HIV will live many years before becoming ill or dying. Work policies that needlessly bar people with HIV from working or attending school serve no genuine public health purpose and seriously impinge on these individuals' rights to work, an education, an adequate standard of living, and realization and enjoyment of their full potential as human beings.

Discriminatory policies also deprive society of the contribution of many skilled individuals. In countries without comprehensive social services, loss of employment or denial of an education also leaves people with HIV infection and their families vulnerable to exploitation, hunger, homelessness, and continued transmission of HIV. Thus, anti-discrimination provisions are necessary to protect those with HIV infection and to reduce the vulnerability of others.

Outreach to Stigmatized Groups

HIV disproportionately burdens the poor, minorities, and marginalized people. Effective prevention and care programs depend on successful outreach to people without adequate health care or preventive services. Criminal provisions may interfere directly with public health efforts to promote safer behavior (e.g.,

criminalizing syringe possession by injecting drug users, or possession of condoms by sex workers). Underlying prejudice may make health care providers less sensitive to the needs of the poor and minorities. Stigmatized people such as drug users, homosexuals, bisexuals, trans-gendered people, and sex workers may fear identification (or prosecution) and may be unwilling to come forward to participate in programs.

Care in Congregate Settings

The military, prisoners, orphans, the elderly, the mentally ill, refugees, and the homeless may reside in congregate settings. These may range in size from a handful of people to thousands of residents, and they vary tremendously in purpose, structure, resource level, and the restrictions placed on inhabitants. Congregate settings, however, raise common human rights issues, including:

- # the right to safe living conditions that do not further compromise the residents' health
- # the right to humane and dignified treatment for those with physical or mental illness, including HIV/AIDS
- # the right to basic preventive health care, including vaccinations, and access to the means to protect themselves from infectious diseases (e.g., condoms and clean syringes)
- # the right to nondiscrimination based on HIV status or membership in minority religious, political, or ethnic population.

Residents of congregate settings usually experience some compromises of their basic human rights based on the needs of the institution. Responding to HIV/AIDS in such settings requires systems that respect the dignity and rights of each individual to the greatest degree possible, particularly by protecting individuals from exploitation or victimization at the hands of fellow residents or staff members.

Clinical Trials

Early in the HIV/AIDS epidemic, health officials realized that HIV/AIDS research had the potential to raise troubling ethical and human rights issues. Recognizing that research into HIV vaccines could both benefit and endanger research subjects,

the WHO Global Programme on AIDS¹³ issued guidelines in 1989 (WHO 1989a; WHO 1986). These guidelines stressed the need to respect international research norms and human rights in the design, enrollment, evaluation, and sharing of benefits of trials in developing countries. They stipulated that research must conform to ethical and human rights principles, including respect for autonomy (informed consent), protection of research subjects, compensation for subjects injured in trials, and equitable sharing of benefits and burdens of research.

In 1991 and 1993, the Council of International Organizations of Medical Sciences (CIOMS) issued updated guidelines governing all international biomedical and epidemiological research (CIOMS 1991; CIOMS 1993). These stipulated that research in developing countries should address health issues important to those countries and that the results and benefits of the research should be shared with the populations that bore the risk and burdens of the research.

The HIV/AIDS pandemic has precipitated major changes in public perceptions of clinical trials in many industrialized countries. HIV/AIDS advocates and people with HIV have demanded and achieved greater access to clinical trials and to drugs outside clinical trials for “compassionate use.” Advocates’ pressure has also led to more inclusive trials which provide more information on disease and treatment efficacy in women, minorities, and children (Johnson and Fee 1994).

A THEORETICAL FRAMEWORK FOR INTEGRATING HUMAN RIGHTS INTO HIV/AIDS PROGRAMS

Many forces shape the HIV/AIDS prevention and care policies of a particular country, province, city, or institution. The way people and societies respond to an HIV/AIDS epidemic is affected by tradition, economic constraints, the availability of trained professionals, the demographics of the local epidemic, and the scientific evidence available. Although many public health officials have experience negotiating the economic and social, and even the political, realities of making HIV/AIDS policies, few are experienced in considering the role of human rights in public health policy. This section examines several different approaches for evaluating the impact on human rights of a country’s HIV/AIDS policies and for evaluating the degree to which the country has integrated human rights into its

¹³WHO/GPA was replaced on January 1, 1996, by the Joint United Nations Programme on AIDS (UNAIDS), which coordinates the HIV/AIDS activities of five UN organizations (including WHO) and the World Bank.

policymaking, legal system, and system of social supports. International funding agencies can use these approaches both to evaluate specific HIV/AIDS programs and to identify population groups vulnerable to HIV/AIDS.

Analyzing Policies that Limit Individual Rights

International human rights doctrines and many national legal systems recognize the protection of public health as a legitimate grounds for restricting certain human rights, and policymakers often justify programs that limit human rights on these grounds.¹⁴ If applied indiscriminately, however, the public health justification can permit extensive infringement of individual liberties, which may be contrary to existing human rights standards and unnecessary to achieve the desired public health goals. Such infringements may even be counterproductive to the broader public health goals served by the policy if they foster mistrust of public health programs or discourage people from participating in them.

The power to limit human rights is narrowly proscribed by requirements established in the fundamental human rights documents and by specific principles summarized by international bodies.¹⁵ For example, international human rights instruments never permit the limitation or abrogation of “non-derogable rights,” as noted above.¹⁶ Other rights, including liberty, freedom of expression, and freedom of association, may be limited only under certain conditions.

In 1984, human rights experts and others convened in Siracusa, Italy, to elaborate the steps required to establish a state’s authority to limit civil and political rights under existing human rights documents. The result was the Siracusa Principles on the Limitation and Derogation Provisions in the ICCPR (UN 1984), which describe the minimum standards states must meet when proposing to limit otherwise protected rights. Such restrictions must be:

prescribed by law in a democratic society

¹⁴In general, in UDHR, Article 29.2, and ICCPR, Article 4.1. Public health is explicitly mentioned as grounds for limiting human rights in UDHR Articles 12.3, 18.3, 19.3, 21, and 22.2. Limitations permitted by law are included in UDHR Articles 9.1, 13, and 17.

¹⁵ICCPR, Article 4; ICESCR, Article 4; Siracusa Principles (UN 1984); Limburg Principles on the Implementation of the ICESCR.

¹⁶ICCPR, Article 4.2.

- # neither arbitrary nor discriminatory
- # based on objective considerations
- # necessary to protect a valued social goal, such as protecting the public health or general welfare
- # proportional to their social aim
- # narrowly tailored to achieve their goal. (UN 1984)

Policymakers can use the International Bill of Human Rights, the Siracusa Principles, and other interpretive documents as tools for reviewing the legality of HIV/AIDS-related policies that limit human rights, just as they use cost-benefit analysis or epidemiological studies and modeling as tools to predict the probable course of an epidemic.

Developing Policies that Reduce the Burden on Human Rights

HIV/AIDS policymakers face the complex and challenging goals of protecting the public health by limiting the further spread of HIV, a highly communicable and often deadly virus, while simultaneously protecting the fundamental dignity and rights of both those who are infected with HIV and those who are not. The challenge is increased by the fact that, because of widespread public fear about the virus, those infected with HIV often face discrimination and stigmatization.

To achieve these sometimes-competing goals, policymakers must constantly improve the efficacy of HIV/AIDS policies while reducing their burden on human rights. There are four aspects to this policy development and review process:

- # reviewing the strict legality of HIV/AIDS policies
- # evaluating the public health goals of such policies
- # assessing whether the means adopted can achieve those goals
- # weighing whether the benefits outweigh the financial and human rights burdens.

Although international human rights principles and instruments can assist policymakers in the first task (reviewing the strict legality of various HIV/AIDS policies), they provide no direct assistance to policymakers for the other three. A

group of people at the Harvard School of Public Health (including this author) therefore developed a system to assist public officials in developing HIV/AIDS strategies, policies, and programs that protect public health and welfare while minimizing the burden on human rights: the Human Rights Impact Assessment (HRIA).¹⁷ This seven-step process for reviewing public policies and programs to assess their human rights impact and ensure their conformity with international norms for limiting human rights is described in practical terms below. Although the HRIA represents only one approach for assessing the human rights impact of public health-related policies, this approach has been adapted for practical use by HIV/AIDS program planners and human rights advocates interested in HIV/AIDS policy (IFRC 1995; Gostin and Lazzarini 1997).¹⁸

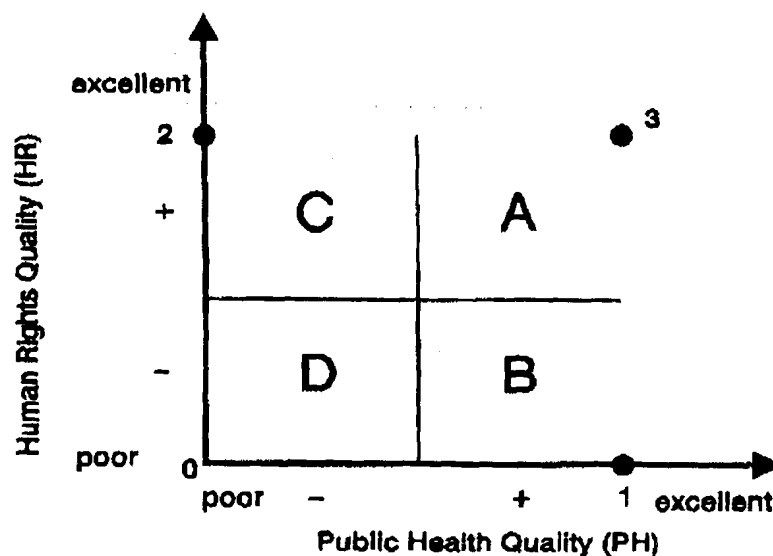
CONDUCTING A HUMAN RIGHTS IMPACT ASSESSMENT OF HIV/AIDS POLICIES

The purpose of the seven-step HRIA is to review both the public health efficacy of a policy or program and its possible impact on human rights, with the aim of identifying the most effective, least burdensome alternative. A practical handbook published by the International Federation of Red Cross and Red Crescent Societies on AIDS, health, and human rights (IFRC 1995) provides a graphic representation of a human rights impact assessment analysis (see Figure 2).

¹⁷First published in Gostin and Mann (1994); appearing with further developments in IFRC (1995) and Gostin and Lazzarini (1997).

¹⁸No data currently establishes how extensively the HRIA is being used.

Figure 2. The Human Rights Impact Assessment (HRIA)



Sector explanation:

A: best case

B: need to improve HR quality

C: need to improve PH quality

D: worst case, need to improve both PH & HR quality

Points explanation:

0: poor quality

1: ideal PH quality

2: ideal HR quality

3: ideal PH + HR quality

Source: IFRC. *AIDS, Health and Human Rights: An Explanatory Manual*. Geneva: International Federation of Red Cross and Red Crescent Societies; Boston: François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health, 1995.

1. Find the facts.

As scientists, public health officials understand the imperative of basing scientific judgments on objective criteria. In the context of HIV/AIDS, that usually means collecting and analyzing epidemiological, clinical, and behavioral data as part of shaping broad policies and then applying those policies to particular individuals. Just as scientists must avoid potential bias or confounding in ascertaining medical or epidemiological data, policymakers should utilize the widest possible range of sources for information on the probable human rights impact of public health measures. (Previous sections of this paper review both important human rights principles commonly implicated in HIV/AIDS programs and specific program elements that generally raise human rights concerns.)

Because they may be less accustomed to collecting and analyzing data on the human rights impact of particular policies, policymakers may need to consult people or organizations experienced in human rights even to determine where to look for possible human rights impacts. They should also consult sources other than governments, including nongovernmental organizations (NGOs), community-based organizations (CBOs), advocacy groups, and community leaders, including clan, religious, or tribal leaders.

2. Determine whether the public health purpose is compelling.

Absent a compelling public health purpose, policymakers cannot justify significantly burdening human rights, and even an important public health goal will not justify a blanket abrogation of human rights. For example, torture, murder, genocide, and inhuman or degrading treatment can never be justified, regardless of the potential public health benefit.¹⁹ Determining whether the purposes of an HIV/AIDS policy that limits human rights is compelling involves three tasks:

- # Clearly defining the goal of the policy: Public health programs or policies should always have specific goals, even if only to ensure that public health resources are being used efficiently. This is particularly important for programs that burden human rights. These goals should be defined narrowly; “preventing disease” is too general a goal. The goal could identify the specific behaviors, conditions, or events the program seeks to effect — for example, identifying

¹⁹These rights are listed in the ICCPR, Article 4.

- people dually infected with HIV and tuberculosis (TB) and ensuring that they complete effective TB prophylaxis or treatment.
- # Evaluating the country's (or other governmental body's) priorities: The public health goal of the policy should fit the country's priorities. HIV prevention efforts aimed primarily at reducing unprotected intercourse among men who have sex with men would not serve a compelling purpose in a country that has a rapidly growing epidemic among injection drug users (IDUs) and heterosexuals.
 - # Understanding the underlying epidemiology of the epidemic: The public health goal of the policy should also fit the realities of the local epidemic, as the example above demonstrates.

3. Evaluate how effectively the policy will achieve its purpose.

After clearly articulating a compelling public health purpose, policymakers must determine whether their proposed policy would effectively achieve that purpose. This step requires a rigorous evaluation of the probable impact of the policy, which takes into consideration both its intended effects and possible reactions by individuals or groups to the policy (its unintended effects). This step is vital to avoid implementing a policy that might expend scarce resources and infringe on individual rights without bringing any ultimate benefit to individuals or to public welfare.

Evaluating the public health efficacy involves asking questions tailored to the specific policy in question. These may include:

- # Is the type of intervention appropriate and accurate (for example, how accurate is the screening test for the target population)?
- # Is the intervention likely to lead to effective action (for example, are there adequate referral systems or provisions to support behavior change)?
- # Have the people involved consented?
- # Will this policy be as effective as other policies (that is, what are the opportunity costs)?

4. Determine whether the policy or program is well targeted.

If a public health policy is determined to serve a compelling public health purpose and promises to effectively achieve that goal, policymakers must then decide how to implement the policy. The goal is to narrowly tailor policies and programs that burden human rights to reach the people who will benefit without unnecessarily interfering with the lives of others.

Policies and programs may fail on this criterion in two ways:

- # The policy or program may be over-broad — that is, it may burden more people than necessary to achieve the stated public health goal. For example, a policy of confining everyone infected with HIV needlessly deprives many individuals of liberty, a fundamental right, without regard to whether they pose any risk of transmitting the infection to others. People with HIV who refrain from having unprotected sex or sharing used hypodermic needles pose little or no risk to family members, co-workers, or members of the community at large.
- # The policy or program may be under-inclusive — that is, it may fail to reach individuals who might benefit from the policy in ways that appear discriminatory. For example, a policy that requires testing of donated blood and tissue for HIV but which applies only to government-operated blood banks would not protect individuals who are served by private blood banks.

5. Examine each policy or program for possible human rights burdens.

Public health officials or donors must balance the efficacy of HIV/AIDS policies and programs with their potential burden on human rights. Even highly effective policies may burden human rights. Relatively minor infringements on privacy or autonomy may be justified by a potentially effective program that serves a compelling public health purpose. For example, some TB treatment programs include temporary isolation, court-ordered treatment, or direct observation of therapy and thereby impose short-term (6- to 18-month) infringements on liberty and limits on privacy and autonomy. These infringements may be justified by the fact that TB is one of the leading opportunistic infections among persons with HIV worldwide and that effective TB treatment may substantially reduce TB transmission among vulnerable HIV-infected people.

Policymakers may use the following four factors in measuring the human rights burden of a proposed policy:

- # The nature of the human right: Interventions that burden essential rights, such as life or freedom from inhuman or degrading treatment, may never be tolerated, while those that burden less absolute rights, such as freedom of association, privacy, or autonomy, may be justified under certain circumstances.
- # The frequency and scope of the human right infringement: Minor, one-time infringements will be easier to justify than those that are serious and frequent.
- # The duration of the human right infringement: This can be illustrated by comparing the isolation or quarantine of people with TB, an airborne infectious disease, for the brief period when they are infectious, with the long-term confinement of people with HIV, who remain infectious for life with a disease spread only through the exchange of bodily fluids — the former is generally acceptable, and the latter is clearly unacceptable.
- # The invasiveness of the intervention: Policies that impact the rights of a few people may be justified, whereas a policy that deprives whole population groups of their rights might not be.

Policymakers should examine this last factor critically, since policies that burden the rights of even only a few individuals might impermissibly discriminate against them, for example, if the infringement is permanent.

6. Determine whether the policy is the least restrictive way to achieve the public health objective.

In addition to weighing its efficacy and human rights burdens, policymakers should consider whether the policy or program in question is the least burdensome alternative that will achieve the public health goal (UN 1984). This *does not* require policymakers to choose less effective alternatives; the emphasis is on choosing among alternatives that are equally effective in achieving the stated public health goal based on which will impose fewer burdens on the important rights of individuals. For example, voluntary programs that are linked to the provision of services or social support may be more effective in reaching people with HIV infection or at high risk of infection than policies that are coercive or that do not involve support and services. Programs that emphasize trust, cooperation, and voluntarism may have a longer-lasting impact on individual behavior than those that intrude deeply on individuals' private motivations, beliefs, or actions.

7. If a coercive policy or program is truly the most effective and the least restrictive alternative, base its implementation on the “significant risk” standard and guarantee procedural justice.

Determining “Significant Risk”

If, after completing this analysis of a proposed HIV/AIDS policy, public health officials conclude that coercion or substantial human rights burdens are necessary, the measures used to implement the policy or program should be evaluated as they apply to each individual who will be affected. This step ensures that the policy or program will impose human rights burdens only where necessary to avert a “significant risk” of harm to others. This determination of risk should not be based on fear, stereotypes, or prejudices. For example, before an individual infected with HIV is barred from a job or an educational institution or is confined, authorities should determine whether individual poses a real and significant risk of harming others. Ideally, policymakers examining an HIV/AIDS policy will carefully consider the possible modes of HIV transmission in a particular setting or case, as well as the probability of transmission based on the behavior of the individuals in question. HIV/AIDS is a serious threat to public health and general welfare, but the seriousness of HIV *if it is transmitted* should not be allowed to “trump” other factors and used to justify exclusion or confinement when the actual probability of transmission is very low or approaches zero.²⁰

Guaranteeing Procedural Justice

Before depriving an individual of important rights and liberties, public health officials should ensure that the process fulfills notions of “procedural justice” — specifically, that it is fair, provides the individual with an opportunity to dispute the restrictions, and preserves the individual’s rights to future review of the restrictions. International human rights norms require that health officials provide a public hearing for individuals before depriving them of important rights, including liberty and freedom of movement (as do the doctrine of “natural law” and the American constitutional concept of “due process”). The nature and scope of

²⁰In *Glover v. Eastern Neb. Com. Office of Retardation*, 686 F. Supp. 243 (D. Neb. 1988), the trial court declares that even when a disease is serious or fatal, fairness and respect for individual rights demand that a minimal or highly speculative risk of transmission cannot support invasive or coercive policies, where the measure serves no true public health purpose.

procedural fairness for public health restrictions closely parallels those required for mental health confinement.

Procedural justice or fairness serves important substantive goals: promoting accurate fact-finding, discouraging discrimination based on fear or prejudice, and encouraging frequent review of public health approaches to HIV/AIDS control.

RESPECT FOR HUMAN RIGHTS AS A MEASURE OF SOCIETAL VULNERABILITY TO HIV INFECTION

Societies that do not protect and promote key human rights create fertile ground for the spread of HIV (Mann and Tarantola 1996; Zierler and Krieger 1997). When people do not have the knowledge or the means to protect themselves, or when they must put daily survival above practicing safe sex or avoiding drug use, they are vulnerable to HIV infection. This means that girls who are denied equal access to education, women who cannot get jobs or credit, and women and children who are exploited in the sex or drug trades are all vulnerable to HIV infection. It means that people whose governments stifle the full and free exchange of information, or block access to scientific advances, are vulnerable to HIV infection. And it means that people who lack the means to earn an adequate standard of living, social security, food, or education are vulnerable to HIV infection. Societies that try to reduce the spread of HIV through coercive policies may deceive themselves about the effectiveness of their response to the epidemic, drive those affected underground, or create pockets of vulnerability.

Policymakers, advocates, and donors can consider local or national respect for key human rights to be a measure, albeit partial, of societal vulnerability to HIV infection. A number of governmental and nongovernmental organizations publish periodic reviews of human rights conditions in many countries.²¹ Although none of these is specifically aimed at evaluating respect for human rights in a country as it relates to health, each may provide useful information to those considering human rights measures as part of an HIV/AIDS prevention and control strategy.

Such an approach would have correctly identified several countries that experienced the most rapid growth in HIV/AIDS during the last decade, including Thailand and India. The explosion in HIV prevalence in Thailand during the late 1980s was presaged by a booming sex industry that employed many young

²¹See US Department of State (1998) and the annual reports published by such groups as Human Rights Watch and Amnesty International.

women, girls, and boys, sometimes against their will, with little protection, little access to health care, and little or no health education. HIV spread rapidly among this vulnerable group and then among others in society.

In India, where the epidemic surged during the mid-1990s, many people lack access to basic education, jobs, health care, and health information. Social and cultural practices emphasize the subordinate role of women in intimate relationships and discourage women from talking about or learning about sex (Mane 1996). Laws based on religious codes deny some women equal treatment before the law in the context of marriage and family life. Finally, HIV/AIDS prevention and care programs face barriers from governmental, legal, and social practices that violate basic human rights.

The WHO Global Programme on AIDS (GPA) proposed creating a database of country-specific data on human rights conditions related to HIV/AIDS in 1994, as well as developing indicators to measure ongoing efforts in countries to reduce HIV-related discrimination (UNHCHR 1996b). Completion of these projects would provide important tools to HIV/AIDS strategic planners and should be supported.

RECOMMENDATIONS

Policymakers, researchers, and donors can take three immediate steps to integrate human rights standards into both the planning and implementation of HIV/AIDS programs:

1. Review national HIV/AIDS strategies against the UNAIDS guidelines.

Those concerned with HIV/AIDS policies, whether domestically or internationally, can use the UNAIDS guidelines to review the whole of a country's approach to HIV/AIDS (UNHCHR 1996a). The guidelines, which are summarized in Annex A of this paper (pp. 40–41), include both legal and administrative steps (e.g., integration of human rights into national strategies, law reform, allocation of resources to social programs, and monitoring and enforcing human rights) and process concepts (e.g., an emphasis on community participation and creating a supporting and enabling environment). Individual policies and programs could be reviewed in an effort to ensure that only those elements that advance particular parts of the guidelines be implemented. For example, any initiative for HIV/AIDS

care or prevention could be critically reviewed to ensure that it incorporates community participation.

2. Minimize the human rights impact of HIV/AIDS policies and programs.

Before donors and policymakers can identify which policies and programs will minimize the burden on human rights while achieving desired public health goals, they must clearly articulate the public health purposes of individual policies and programs, assess their human rights burdens, and critically evaluate whether the burdens are necessary, authorized by law, and proportional to the expected benefits (Gostin and Lazzarini 1997).

Donors and policymakers can conduct such analysis using established international human rights documents and principles, including the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR, especially Article 4), the International Covenant on Economic, Social and Cultural Rights (ICESCR, especially Article 4), and the Siracusa Principles (UN 1984). Ideally, however, they will utilize a method that incorporates an assessment of both public health efficacy and the impact on human rights, and a mechanism for minimizing the burden on human rights, such as the Human Rights Impact Assessment (HRIA) outlined in this paper.

3. Examine the impact of policies and programs on reducing general vulnerability to HIV infection.

Policymakers and donors can consider respect of key human rights as a bellwether of general societal vulnerability to HIV infection, and they can examine whether individual policies and programs successfully reduce the overall vulnerability of individuals, groups, and societies to HIV infection. In particular, they can examine whether policies and programs

- # move beyond “passive” delivery of health information or treatment
- # promote cooperation and action in communities and nations that will effectively address issues of social injustice that make people and societies vulnerable to HIV/AIDS and negatively impact the lives of those with HIV/AIDS.

RESEARCH AGENDA FOR FUTURE IMPLEMENTATION

Research to improve the design and implementation of programs and policies that integrate human rights into HIV/AIDS programs could seek three broad goals:

1. Tracking the relationship between the burden on human rights and vulnerability to HIV infection.

Such research could help determine how program interventions can better protect individuals' human rights and thereby reduce their vulnerability to HIV infection. Individual projects could link HIV prevalence data to

- # data on social, economic, and political conditions that burden human rights
- # data on incidence of violence against women (e.g., reports of global and culturally specific manifestations of violence, wife beatings, rape and murder, dowry deaths, honor murders, *saiti*)
- # data on the civil services available in particular geographic areas (e.g., water, fire, police, recreation, and other municipal services)
- # data on existence and support for social programs (e.g., universal free education, public assistance, health care, and drug treatment). ²²

Research in this area could also focus on developing an "AIDS impact statement" that would measure the impact of proposed economic and social policies and programs on HIV/AIDS incidence. WHO's proposed database on human rights conditions related to HIV/AIDS and its proposal to develop indicators to measure progress in reducing HIV-related discrimination (UNHCHR 1996b) would also yield critical data.

²²These are derived from Zierler and Krieger's (1997) recommendations for research on the U.S. HIV epidemic and adapted to an international context.

2. Establishing the relationship between promoting human rights, reducing HIV transmission, and increasing the well-being of those with HIV.

This would include projects related to those outlined above, but the emphasis would be on studying interventions that promote rights, increase participation and opportunity in society, and provide support for those infected with HIV and their families. Empirical evidence of the efficacy of these approaches is vital if countries are to adopt and sustain approaches to HIV/AIDS that can challenge deeply held beliefs, established traditions, and existing institutions.

3. Researching equity of access and resource allocation.

This would include projects that seek to reduce inequalities in the realization of human rights and health status between rich and poor (both individuals and nations). These projects could include:

- # promoting access by the poorest to better prevention and care services
- # evaluating innovative outreach programs that empower and engage communities at risk
- # seeking to maximize health benefits from use of scarce resources (e.g., studies of effective and affordable regimens to reduce perinatal HIV transmission, short-course TB treatment and prophylaxis, the role of micronutrients in HIV infection and disease history, promoting safe, compassionate, comprehensive home care in developing countries, and the efficacy of “alternative” treatments).

In the broadest sense, this type research could document and try to replicate successful efforts to make effective interventions available to the poorest communities (through donations, special licensing agreements, cooperative work or research agreements).

Many of these research goals could be addressed in combination with other research on HIV/AIDS care and prevention, health and human rights in general, and, often, with the direct provision of services or interventions. One way of conceptualizing these research goals would be to add an “human rights component” to as many new or ongoing projects as possible. Much of the data that

are valuable to human rights and HIV/AIDS research may be collected by or made available to those doing social, behavioral, epidemiological, or clinical research. Incorporating human rights data collection and analysis into these projects could provide valuable information and an important variety of perspectives. Independent human rights research may also examine elements of other health-related projects, because failures to protect and promote human rights can predispose people to a wide range of health threats. Documenting the relationship between human rights and other health problems may provide insight into the relationship between human rights and HIV/AIDS.

Annex A: A Review of Efforts to Integrate Human Rights into HIV/AIDS Programs

THE UNITED NATIONS

The United Nations has focused and coordinated international efforts to combat HIV/AIDS since the late 1980s,²³ primarily through its constituent organizations the World Health Organization (WHO) and the Joint UN Programme on HIV/AIDS (UNAIDS), which was established in 1996 and coordinates the HIV/AIDS activities of five UN organizations (including WHO). The UN efforts, as developed through HIV/AIDS-specific resolutions and reports, have consistently expressed certain themes:

- # global and national strategies should reflect a deep respect for human rights
- # policies should emphasize voluntary approaches (autonomy, cooperation, consent, education)
- # persons with HIV infection or AIDS have the right to privacy and confidentiality of health care information
- # invidious discrimination violates the rights of persons with HIV/AIDS and makes others vulnerable to infection. (Gostin and Lazzarini 1997)

This section briefly describes activities of the World Health Assembly (WHA) and WHO, the scope of HIV/AIDS-specific resolutions and guidelines, UN treaty bodies' HIV/AIDS-related actions, and the formation of UNAIDS.²⁴

²³See Garbus (1996) and UNHCHR (1996a).

²⁴Space precludes a full description of the United Nations' activities in the areas of HIV/AIDS, for more information see cited material.

The World Health Assembly (WHA)

The WHA, the governing body of the World Health Organization, adopted a series of key resolutions illustrating the organization's stand on human rights as part of HIV/AIDS control and prevention:

- # the need for international cooperation in research and education concerning HIV/AIDS (WHA 1987)
- # the primacy of nondiscrimination (WHA 1988)
- # disapproval of public health as a rationale for measures that arbitrarily limit individual rights in relation to HIV/AIDS (WHA 1992).

World Health Organization (WHO)

The WHO's Global Programme on AIDS (GPA) integrated respect for human rights into its efforts to initiate, support, and coordinate national, regional, and international HIV/AIDS strategies.²⁵

The WHO, alone or with other organizations, issued guidelines covering a wide range of HIV-related issues which emphasized the crucial roles of nondiscrimination and respect for human rights. HIV/AIDS-specific documents have addressed questions of the proper uses of HIV screening, sexual behavior, the role of sexually transmitted infections (STIs), pregnancy, breastfeeding, and HIV/AIDS in prisons and in the workplace.²⁶ Virtually all the UN-affiliated organizations have issued their own statements on HIV/AIDS or expressly adopted WHO nondiscrimination policies.

United Nations Commission on Human Rights (UNHCHR)

The human rights monitoring organizations and treaty bodies within the United Nations have also addressed HIV/AIDS-related issues in the context of human rights. The Commission on Human Rights (UNHCHR) and its Sub-Commission on Prevention of Discrimination and Protection of Minorities commissioned a special review of HIV/AIDS-related discrimination (UNHCHR 1991, 1992, 1993). These reports detailed HIV/AIDS-related human rights concerns around the globe and made recommendations for national and international action. The special

²⁵See WHA (1987, 1988, 1989, 1992, 1993).

²⁶See WHO (1987a, 1987b, 1987c, 1988, 1989b, 1989c, 1989d, 1991, 1992a, 1992b, 1993); WHO/UNICEF (1992).

rapporteur identified women and children as groups most at risk of discrimination and exploitation and thus the most vulnerable to HIV/AIDS (UNHCHR 1993). The Commission and Sub-Commission subsequently adopted resolutions emphasizing the importance of human rights and condemning discrimination in the context of HIV/AIDS.²⁷ In 1996, the Secretary-General, reporting to the Commission on Human Rights, underscored the need for coordinated action to protect human rights in the context of HIV/AIDS, reduce vulnerability to infection, and promote the rights of those already infected. Specifically, the report noted that national governments, NGOs, UNAIDS, and the existing international human rights machinery play crucial roles in monitoring and reporting on progress in protecting human rights in the context of HIV/AIDS (UNHCHR 1996b).

Joint United Nations Programme on AIDS (UNAIDS)

In the early 1990s, the United Nations recognized an increasing need for system-wide coordination of HIV/AIDS-related activities. The Joint United Nations Programme on AIDS (UNAIDS) consolidates the efforts of its six co-sponsors: United Nations Development Programme (UNDP); United Nations Population Fund (UNFPA); United Nations Children's Fund (UNICEF); United Nations Educational, Social and Cultural Organization (UNESCO); WHO; and the World Bank.

UNAIDS became fully operational in January 1996. UNAIDS has four goals:

- # reducing HIV transmission
- # increasing both quality and accessibility of HIV care
- # reducing individual and collective vulnerability to HIV
- # reducing the adverse impact of HIV/AIDS on the health, livelihood, and well-being of individuals and communities.

²⁷United Nations Commission on Human Rights. "The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)," Resolutions 1995/44 (March 3, 1995); 1994/49 (March 4, 1994); 1993/53 (March 9 1993). United Nations Commission on Human Rights. Sub-Commission on the Prevention of Discrimination and Protection of Minorities. "Discrimination in the Context of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)," Resolutions 1995/21 (August 24, 1995); 1994/29 (August 26, 1994).

Notably, UNAIDS represents a formal commitment by UN agencies with otherwise disparate mandates to core principles, including promoting respect for human rights (UNHCHR 1996b). UNAIDS also supports efforts to increase access to the benefits of emerging scientific discoveries to people around the world.

In September 1996, the UNHCHR and UNAIDS convened the second international consultation on HIV/AIDS and Human Rights in Geneva. The consultation brought together 35 experts in HIV/AIDS and human rights, who considered regional documents and background papers from NGOs and networks of people living with HIV/AIDS. The consultation produced guidelines for states to promote and protect human rights in the context of HIV/AIDS (UNHCHR 1996a). The guidelines enunciate normative principles, identify practical strategies for implementing programs that conform to the guidelines, and provide commentary on the principles and strategies.

The guidelines divide recommended state activity into three areas:

Defining institutional responsibilities and processes (guidelines 1-2):

1. Establish a national framework for developing and implementing HIV/AIDS policies
2. Support community partnerships.

Reviewing and reforming laws and support services (guidelines 3-7):

3. Review and reform public health legislation
4. Review and reform criminal laws
5. Enact or strengthen anti-discrimination laws
6. Regulate HIV-related goods, services, and information to ensure availability, safety, efficacy, and affordability of preventive measures and means, treatment services, and medications
7. Implement and support legal services for people affected by HIV/AIDS.

Promoting a supportive and enabling environment (guidelines 8-12):

8. Promote a supportive and enabling environment for women, children, and other vulnerable groups
9. Work to change discriminatory attitudes through education, training, and the media
10. Develop professional standards that integrate human rights into codes of conduct and permit enforcement
11. Monitor and enforce HIV-related human rights

12. Cooperate with international efforts to promote human rights, prevent the spread of HIV/AIDS, and provide optimal care to those infected.

These guidelines provide important information, not only to health officials designing domestic HIV/AIDS policies that respect and promote human rights, but also to national and international organizations that support programs in multiple countries and wish to encourage greater and more uniform integration of human rights into HIV/AIDS policies.²⁸

SELECTED NATIONAL, REGIONAL, AND NGO PROGRAMS

National Programs

Many countries include language reflecting a commitment to respect human rights or to avoid discrimination in their national policies, national HIV/AIDS advisory boards, or national HIV/AIDS strategies. A perusal of country reports on implementing HIV/AIDS strategies, such as those submitted to WHO or UNAIDS, provides evidence of admirable intent. Identifying countries that have actually successfully integrated human rights into HIV/AIDS policies at all levels, and therefore might serve as models for other efforts, however, presents considerable difficulty. In fact, one recent UN report notes the “dramatic gap” apparent between national HIV/AIDS policies and legislation and their implementation (UNHCHR 1994; Parker 1996). Consequently, this section describes reports of particular programs or initiatives that have been successful in integrating human rights.

In Australia, Canada, the United States, South Africa, and some countries in Latin America legal advocates and policymakers are pursuing ongoing law reform programs. In some, legislatures have successfully drafted and adopted general anti-discrimination legislation that defines disability broadly enough to cover HIV infection and AIDS (UNHCHR 1996b). Such legislation currently exists in the United States,²⁹ the United Kingdom, Australia, New Zealand, and Hong Kong.

²⁸Although the guidelines provide much additional helpful information, complete elaboration of the strategies and commentary is beyond the scope of this paper.

²⁹In the United States, protection of people with HIV infection under the Americans with Disabilities Act (ADA) is being challenged now in the U.S. Supreme

Other countries, such as France, have provisions with similar effect elsewhere in their legal codes. Canada has established a committee at the federal level that oversees the development of all public health policy related to HIV/AIDS from the perspective of protecting human rights (UNHCHR 1994).

Since the beginning of the epidemic, the Netherlands has emphasized voluntarism in all its approaches to HIV/AIDS. For some time, it was the only country in western Europe with voluntary (as opposed to mandatory) reporting of AIDS cases to public health authorities (Curran, Gostin, and Lazzarini 1991). The central role of consent in HIV testing in all settings also led the Netherlands to reject unlinked anonymous screening as an HIV surveillance tool (Bayer, Lumey, and Wan 1991). In the Netherlands, extensive legislation and constitutional provisions protect individuals' physical integrity, privacy, and freedom from discrimination (UNHCHR 1996b).

Recently, advocates and representatives from government and industry in the Netherlands debated whether companies could require HIV testing of individuals who apply for life insurance or employment disability plans. As most recently reported in UN documents, the result will most likely be a "code of conduct" that protects the rights of applicants and provides a complaint process (UNHCHR 1994).

Some developing countries also have moved to integrate human rights into their responses to HIV/AIDS. The government of Zimbabwe has adopted a policy on nondiscrimination in the context of HIV/AIDS. To make this policy effective, the government has engaged a multi-disciplinary team (comprising experts in law, medicine, communications, sociology, and economics) to draft policies and make recommendations for implementing legislation.

In Mexico, the government has established a National Human Rights Commission to receive complaints from persons discriminated against due to HIV/AIDS. The Commission has also prepared and distributed information to the public on the important human rights of persons with HIV/AIDS (UNHCHR 1994).

Court. The high court is considering an appeal in *Abbott v Bragdon*, 107 F. 3d 934 (1st Cir. 1997), which held that a plaintiff with asymptomatic HIV Infection was protected by the ADA. Oral argument was held March 30, 1998.

Regional Programs

Some regional intergovernmental bodies have adopted explicit policies rejecting HIV/AIDS-related discrimination or otherwise endorsing human rights. The Council of Europe recommended to its members that specific policies should

state unequivocally that HIV-infected individuals have the right to enjoy the same civil and social rights as the non-infected, while bearing ethical, civil, and legal responsibilities to contain transmission. (Council of Europe 1989)

HIV/AIDS-related issues have also made their way, sometimes indirectly, onto the agenda of regional human rights treaty bodies (Gruskin, Hendriks, and Tomasevski 1996). The European Court of Human Rights has ruled on cases involving compensation for a person with hemophilia and disapproved of government assertions that laws criminalizing homosexual conduct are necessary to prevent STDs.³⁰

United Nations agencies also sponsored regional meetings and initiatives on HIV/AIDS and human rights. These have included:

- # the pan-European consultation on HIV /AIDS in the context of public health and human rights in Prague (November 1991)
- # three additional consultations on HIV, law, and law reform for countries in Eastern Europe and Central Asia (1995)
- # consultations on ethics, law, and HIV in the Philippines (May 1993) and Dakar, Senegal (June 1994)
- # training workshops on HIV, law, and law reform in Colombo, Sri Lanka; Beijing; and Nadi, Fiji (1995)
- # a conference on HIV/AIDS, law, and human rights, in New Delhi (December 1995).

³⁰ *X v. France*, European Court of Human Rights, 81/1991/333/406 (March 31, 1992); *Norris v. Ireland*, European Court of Human Rights, 6/1987/129/180 (October 28, 1988).

NGO Programs

Before 1990, traditional human rights NGOs had not involved themselves deeply in HIV/AIDS-related issues. Since then, however, many NGOs have taken steps to include HIV/AIDS-related issues in their human rights mandates, including:

- # Studying HIV/AIDS-related issues occurring within their original mandate (Amnesty International)
- # Adopting new items for their monitoring and research agenda related to HIV/AIDS and human rights (the International Commission of Jurists, ICJ)
- # Focusing on human rights issues related to migrants and refugees with HIV/AIDS (the International Human Rights Law Group)
- # Issuing reports on specific HIV/AIDS-related activities, such as trafficking of women in Thai and Burmese brothels (Asia Watch and the Women's Rights project of Human Rights Watch)
- # Concentrating on monitoring human rights of particular vulnerable groups, such as sexual minorities (the International Gay and Lesbian Human Rights Commission, IGLHRC).

HIV/AIDS-specific NGOs, organizations of persons living with HIV and AIDS (PLWHAs), and community-based organizations (CBOs) continue to monitor and promote the rights of individuals with HIV/AIDS and those vulnerable to infection. NGOs and CBOs play a major role in generating grassroots involvement in HIV/AIDS prevention and health promotion, caring for persons with HIV/AIDS, and monitoring and promoting human rights.

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Annex C: Acronyms

Below is a list of the acronyms used in this report.

ADA	Americans with Disabilities Act (US)
CBO	Community-based organization
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CIOMS	Council of International Organizations of Medical Sciences
GPA	Global Programme on AIDS (WHO)
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HRIA	Human Rights Impact Assessment
HTS	Health Technical Services Project
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICJ	the International Commission of Jurists
IDU	Injection drug user
IFRC	International Federation of Red Cross and Red Crescent Societies
IGLHRC	International Gay and Lesbian Human Rights Commission
NGO	Nongovernmental organization
PLWHA	Person/people living with HIV/AIDS
SIDA	Swedish International Development Association
STI	Sexually transmitted infection
TB	Tuberculosis

UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNHCHR	United Nations Commission on Human Rights
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHA	World Health Assembly (governing body of WHO)
WHO	World Health Organization
WHO/GPA	World Health Organization's Global Programme on AIDS (replaced on January 1, 1996, by UNAIDS)

Annex D: Prevention and Care Dynamic of Human Rights and HIV/AIDS

Figure 3. Prevention and Care Dynamic of Human Rights and HIV/AIDS

Intervention	Immediate Beneficiary	Primary Benefit	Mitigating Effect	Prevention Benefit
Review the strict legality of HIV/AIDS policies and programs	All individuals, including those who are infected with HIV and those who are not	Identifies human rights infringements that may or do result from particular policies and programs	Prevents unlawful and/or unnecessary infringements on important individual rights	May decrease the vulnerability of some people to HIV infection because failure to promote or protect human rights can increase the risks of poor health, including HIV infection
Evaluate the public health goals of such policies and programs and determine whether they are compelling	Individuals and groups whose human rights may be burdened by an HIV/AIDS-related policy or program	Ensures that rights are not unnecessarily or unduly burdened	Prompts policymakers to clearly and narrowly define their goals	Helps ensure that the policy and program goals fit local public health priorities and the nature of the epidemic
Assess whether the means adopted can effectively achieve the goals	<p>P Those who will benefit from the policy or program</p> <p>P Others competing for the scarce resources allocated to the policy or program</p>	Helps improve efficacy and cost-effectiveness of policies and programs	Encourages policymakers to fully examine the potential impact of policies and programs, including the intended and unintended results	Promotes more efficient allocation of scarce resources to maximize the potential benefits of an overall HIV/AIDS strategy

Figure 3. Prevention and Care Dynamic of Human Rights and HIV/AIDS

Intervention	Immediate Beneficiary	Primary Benefit	Mitigating Effect	Prevention Benefit
Determine whether the policy or program is well targeted	Those who will benefit from policy or program and others who will be affected	Ensures that burdens on human rights are proportional to the benefits for all affected	Helps ensure that policies or programs are not under-inclusive (fail to reach people who may benefit in ways that may be discriminatory)	Helps ensure that policies or programs are not over-broad (burden more people than necessary to achieve the stated public health goal)
Examine each policy or program for possible human rights burdens	Those whose rights will be burdened	Determines the likely human rights burdens on various individuals and groups who will be affected	Helps ensure that no individuals' or groups' are impermissibly burdened, either because absolute rights are involved, the infringement is too frequent or too heavy, the burden is too long-lasting (e.g., permanent), or the intervention is too invasive	Ensures that HIV/AIDS prevention and care policies are legally, socially, and politically sustainable over the medium and long term

Figure 3. Prevention and Care Dynamic of Human Rights and HIV/AIDS

Intervention	Immediate Beneficiary	Primary Benefit	Mitigating Effect	Prevention Benefit
Measure the human rights burden on all those affected in terms of the nature of rights affected, the invasiveness of the intervention, and frequency, scope, and duration of the infringements	Those whose rights may be infringed	Establishes the range of human rights burdens that will be imposed on those affected by the policy or program	Helps ensure that the human rights burden on all those affected are fully necessary and justified	Can create conditions in which more people will avoid HIV infection by promoting trust in public health policies and strategies, protecting privacy, preventing discrimination, and maximizing the use of resources
Determine whether the policy or program is the least restrictive way to achieve the public health objective	All individuals in society	Minimizes the burden on important individual rights by effectively achieving compelling public health goals	Programs that are based on trust, voluntarism, and general protection of human rights may be more effective in reaching those infected with HIV	Programs that do not intrude on individuals' private motivations, beliefs, or actions may have a deeper and longer-lasting impact on behavior than those that are coercive or that heavily burden human rights

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Intervention	Immediate Beneficiary	Primary Benefit	Mitigating Effect	Prevention Benefit
If a coercive policy or program is the most effective and least restrictive alternative, base implementation on the significant risk standard and fair processes	Those whose human rights will be burdened	<p>P Ensures that the human rights burden is only on those who pose a significant risk of harming others</p> <p>P Ensures that those whose rights are burden enjoy procedural justice (i.e., public hearing, future review)</p>	<p>P Promotes accurate fact-finding</p> <p>P Discourages discrimination based on fear or prejudice</p>	Encourages frequent review of public health approaches to HIV/AIDS control